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I HAVE NO CHEST PAIN, ONLY I HEAR WHISTLES

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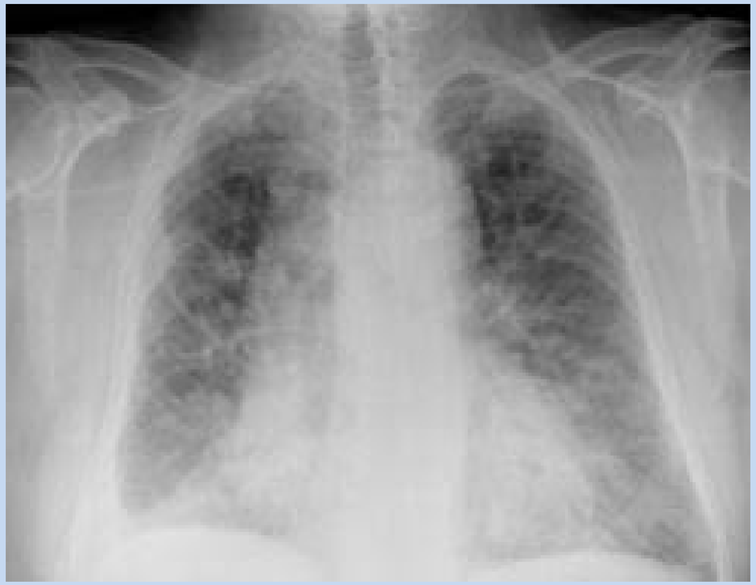
Personal history and reason for inquiry:

76-year-old male. No known allergies. Ex-smoker 10 years ago. No history of interest or treatment as usual, go to your MAP by auto box listening to wheezing. To auscultation presents mitral focus I/IV systolic murmur and crackles of detachment in both bases. It carries out ECG where detected atrial fibrillation with a controlled ventricular response home deciding transportation to hospital. During the wait for the transfer the patient begins with sudden Dyspnea with vegetative courtship Companion without reference at any time chest pain.



Physical examination:

Run by mobile ICU, the patient presents hypotension with tachycardia performing ECG where presents f to 140 bpm with complete left bundle branch block not known previously. Tachypnea of rest with use of accessory muscles and intercostal retractions.

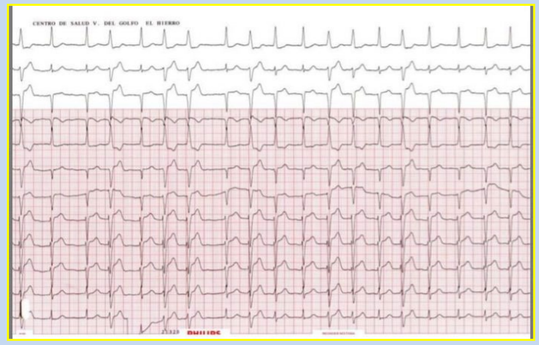
Head and neck: symmetric and palpable carotid pulse.

Cardiac auscultation: Arrhythmic to 130-140 BPM. Mitral focus II/IV systolic murmur.

Respiratory auscultation: MVC with crackling to media in both hemithorax fields.

Abdomen: anodyne.

BSII: without edema and signs of DVT.



Complementary tests:

- Chest x-ray: normal. Bilateral parenchymal infiltrate with both breasts costofrenicos impingement.
- Analytical income: findings of interest.
- Negative serial cardiac enzymes.
- ECG: Atrial fibrillation to 140 lpm with complete left bundle branch block not known.

Evolution:

The patient is stabilized previously the hospital transfer beginning treatment with digoxin IV as well as mechanical ventilation not invasive. It presents improvement of respiratory dynamics and remains in the area of observation prior income in cardiology. During his stay in observation presents episode of ventricular tachycardia that concerns the use of defibrillator twice, making income in ICU where ECO is done cardio is objective only where the existence of a mild mitral regurgitation and right ventricular mild dilatation.

Decides realization of catheterization aiming is 90% of right coronary artery obstruction doing dilatation with balloon and subsequent admission to ICU where after stabilization is transferred to plant of cardiology.

Conclusions:

Is response with atrial fibrillation ventricular rapid which causes coronary right previously stenosed flow deficit without cause necrosis of cardiac tissue although intermittent changes in the system of Cardiac conduction which leads to ventricular tachycardia gusts.